Report on In-Vitro Fertilization and Fertilization Preservation Coverage

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In-Vitro Fertilization and Fertilization Preservation Coverage

Summary

The Department of Financial Services (DFS) has studied the feasibility of mandating coverage of medically-necessary fertility preservation (FP) and in-vitro fertilization (IVF) services in comprehensive commercial health insurance policies and contracts in New York. In addition to surveying existing coverage and laws in other states, DFS procured an actuarial vendor, Wakely Consulting, Inc. (Wakely), to conduct the financial analysis and project the potential premium impacts of providing such coverage. Based on this study, the State can implement a requirement for medically-necessary FP coverage for cancer or other patients who go through treatment that may affect their fertility. Although the data is limited, Wakely estimates that the provision of medically-necessary FP coverage would have a premium impact of approximately 0.02%, which is a relatively small cost for coverage that has benefits to New Yorkers who suffer illnesses including cancer. The premium impacts associated with IVF would be higher, even if relatively modest in percentage terms. Wakely estimates that adding IVF coverage could increase premiums by approximately 0.5% to 1.1%. We also discuss below, with respect to both medically-necessary FP and IVF coverage, the risk of a state fiscal impact under the Affordable Care Act (ACA) were the State to mandate coverage in the individual and small group markets. Limiting any IVF mandate to the large group market would mitigate this risk.

Background

The Importance of Coverage. A bill requiring coverage of medically-necessary FP and IVF services in comprehensive health insurance policies and contracts would provide meaningful benefits to New Yorkers.

Coverage for medically-necessary FP (e.g., egg-freezing) is an important benefit for cancer patients or other patients who go through treatment that may affect their ability to bear children. Cost may be a deterrent for some patients to receive FP services. DFS has been advised that nurses typically discuss the FP process with cancer patients. Many patients initially seem interested in preserving their fertility, but once the nurse mentions the costs, patients often change their minds. Mandating medically-necessary FP coverage would provide cancer patients, and patients with other eligible medical conditions, with the ability to bear children after their treatment concludes.[1]

IVF is an important benefit for people who face fertility obstacles, including same-sex couples and single women. Although the costs of IVF are decreasing in some geographic areas, access to these services remains cost-prohibitive for many people. Because not all insurers currently cover IVF, coverage is only available to employees of certain employers, or to those who can afford to pay out-of-pocket. Mandating IVF coverage would make the service more widely available to all, regardless of a person's employer, marital status, sexual orientation, gender identity, or socio-economic status.

The importance of medically-necessary FP and IVF coverage must be weighed against the potential premium impact, including the impact premium increases have on the affordability of coverage and the potential increase in the uninsured rate in New York.

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[1] For female patients, FP comprises retrieval, cryopreservation, and storage of ova, but the patient will still require IVF services in the future. The cost of the future IVF services is not included in the FP costs set forth in this memorandum, as they would be included in the IVF costs which are not segregated by FP patients.

Current State of Coverage. Under current New York State law, coverage is required for medical and surgical services for the diagnosis and treatment of infertility when such infertility is the result of malformation, disease or dysfunction.[2] Such coverage includes basic infertility services to diagnose and treat infertility (e.g., initial evaluation, laboratory and other diagnostic testing). Coverage is also required for more comprehensive infertility services (e.g., ovulation induction and monitoring, artificial insemination). Medically-necessary FP is not specifically addressed by current New York statutes. *IVF is specifically excluded from mandated coverage in New York law*, though employers can provide the coverage.

Interpreting the existing Insurance Law provisions covering infertility, in Insurance Circular Letter No. 7 (2017), DFS reminded insurers that the American Society for Reproductive Medicine definition of infertility does not distinguish between heterosexual individuals in a relationship or who are married, individuals in a same-sex relationship or who are married, single individuals, or based on gender identity. Therefore, insurers must provide coverage for infertility treatment to an individual who meets the American Society for Reproductive Medicine's definition of infertility, regardless of the individual's sexual orientation, marital status, or gender identity.

As part of this study, DFS queried insurers who issue comprehensive health insurance policies and contracts in New York as to whether they provide medically-necessary FP and/or IVF coverage.[3] Three insurers offered medically-necessary FP coverage and ten insurers offered IVF coverage. However, all insurers stated that when they offer such coverage, the benefits are only offered in the large group market (groups over 100 employees) and it is at the option of the group whether to purchase such coverage. For medically-necessary FP, the data was not sufficient enough to complete a comprehensive analysis.[4] For IVF, most policies had either a dollar limit (which included lifetime and/or annual dollar limits) or a cycle limit. Of the policies that provided IVF coverage, below are attributes of those policies as a group:[5]

- *Dollar Limits*: Approximately 50% of 2017 policies had lifetime dollar limits ranging from $10,000 to $50,000. The NYS Empire Plan has a $50,000 lifetime limit.
- *Cycle Limits*: Approximately 20% of the policies offered a three-cycle limit with no dollar limits. 6% offered a four-cycle limit with $30,000 to unlimited dollar limits.
- *No Limits*: 6% of the policies offered unlimited plans with no cycle or dollar limits.

Considerations

[2] Insurance Law §§ 3216(i)(13), 3221(k)(6), and 4303(s).

[3] DFS sent inquiries to 12 commercial health insurers, including the insurers who administer the New York State Health Insurance Program for Employees (Empire Plan). DFS received 96 policies and/or riders from the years 2016, 2017, and 2018. DFS also received claims data from 2016 and 2017. The Empire Plan data accounts for 43% of the Downstate data, and 85% of the Upstate data.

[4] Of the three insurers that offered FP coverage, there were 16 claimants over a two-year period, i.e., 2016-2017, indicating low utilization.

[5] These percentages are meant to highlight specific qualities of the policies. Not all attributes were included here (e.g., plans with one or ten cycles, or varying dollar limits). Therefore, the percentages do not add up to 100%.

Medically-Necessary FP Coverage. Amending the Insurance Law's definition of infertility to include coverage for medically-necessary FP services, including storage costs.

As noted above, current State law requires coverage for services to diagnose and treat infertility. State law provides that DFS shall promulgate regulations which shall include the determination of infertility in accordance with standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. The current definition of infertility adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine does not include iatrogenic infertility.[6]

Wakely estimates that the premium impact for adding medically-necessary FP coverage would be less than 0.02%.

Medically-Necessary FP Mandates in Other States.[7] Connecticut, Delaware, Illinois, Maryland, and Rhode Island mandate FP coverage when a medical treatment causes infertility. Other states with pending FP legislation include Arizona, California, Hawaii, Kentucky, Louisiana, Missouri, Mississippi, and Vermont. New Jersey's pending bill was introduced in the Senate on March 5, 2018, and referred to the Senate Commerce Committee.[8]

IVF Coverage. Mandating IVF would likely have a more significant premium impact, from approximately 0.5% to 1.1%, depending on the region and benefit design. Consumers derive large benefits from IVF coverage. The heightened premium impact of mandating IVF coverage must also be considered, particularly in the individual and small group markets, at a time when many New Yorkers are struggling to afford health insurance coverage. In addition, there is a state fiscal risk discussed below. If an IVF mandate were to be enacted, consideration should be given to limiting the number of cycles, while ensuring that coverage is non-discriminatory, and limiting its coverage to large group coverage, including the following parameters:

- Cycle Limits. IVF coverage can include a limit of cycles (the ACA does not permit a dollar limit in the individual and small group markets on essential health benefits). A three-cycle limit would be comparable to the $50,000 lifetime dollar limit currently in the NYS Empire Plan. Alternatively, the State may consider mandating a limit in the number of egg retrieval attempts instead of cycles. Premium impacts of several scenarios are set forth below.[9]

- Definition of Cycle. If an IVF mandate includes a cycle limit, "cycle" can be clearly defined within the statute. Under an insurer's current policy, a "cycle" is defined as either all treatment

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6 Iatrogenic infertility means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

7 Alliance for Fertility Preservation (site visited on January 24, 2019) *available at* http://www.allianceforfertilitypreservation.org/advocacy/state-legislation.

8 New Jersey Legislature (site visited on October 15, 2018) available at https://www.njleg.state.nj.us/bills/BillView.asp?BillNumber=S2133.

9 An IVF procedure has two parts: retrieval of the eggs (and mixing with sperm to create embryos), and implantation of the embryo(s). The retrieval procedure is the more invasive and expensive procedure. Policies in New York tend to consider each implantation as a cycle; therefore, if a patient retrieves five eggs, and she implants one egg at a time, then a three-cycle limit would cover implantation of only three of those five embryos. However, there are states that mandate four to six egg retrievals, and no limits on embryo transfers, i.e., Delaware mandates six retrievals with unlimited embryo implantation; New Jersey and Illinois mandate four retrievals; Illinois permits two more retrievals if a live birth results from a prior retrieval.

that starts: (1) when preparatory medications used for ovarian stimulation with the intent of undergoing IVF are administered for oocyte retrieval, IVF using fresh embryo transfer; or (2) with medications for endometrial preparation with the intent of undergoing IVF with a frozen embryo transfer. The definition of cycle should also consider how to count unfinished cycles towards the cycle limit to ensure that coverage is consistent across all insurers.[10]

- Prohibit Discrimination Based on Marital Status, Sexual Orientation, and Gender Identity. IVF benefits can be written in such a way to ensure that full access is granted to everyone regardless of their marital status, sexual orientation, or gender identity. Benefits must be available for unmarried persons and same-sex couples. This is consistent with DFS's circular letter described above.

- Age Limits. Consider IVF benefits that are not be limited based on age. Instead, IVF coverage can be reviewed based on the patient's medical needs, giving consumers the right to pursue an external appeal under Article 49 of the Insurance Law and Public Health Law. Therefore, consider not applying to IVF New York's current age limits (from the age of 21 to the age of 44) for infertility treatments .

- Prohibit Procedural Hurdles. Currently, other states require exhaustion of other assisted reproductive technology (ART) procedures before IVF coverage is permitted. Each type of procedure has its own risks and rewards; therefore, the statute should not include these limitations, but permit a medical necessity review of treatment. This way, the decision as to which treatment(s) and when would be determined by medical necessity decisions, and review would give consumers the right to pursue an external appeal under Article 49 of the Insurance Law and Public Health Law.

IVF Mandate Premium Impact. The tables below, developed by Wakely, detail the potential premium impact for mandating one IVF cycle, three IVF cycles, or unlimited IVF coverage. For purposes of this analysis, Downstate New York is defined as New York, Kings, Bronx, Richmond, Queens, Nassau, Suffolk, Westchester, and Rockland Counties. Upstate New York is defined as all other counties.

Table 1-A: Projected Per Member Per Month (PMPM) – One Cycle of IVF

Individual	*Low*	*High*
Downstate	0.5%	0.6%
Upstate	0.5%	0.6%

Table 1-B: Projected Per Member Per Month (PMPM) – Three Cycles of IVF

Individual	*Low*	*High*
Downstate	0.7%	0.8%
Upstate	0.7%	0.9%

Table 1-C: Projected Per Member Per Month (PMPM) – Unlimited Cycles of IVF

[10] At times, eggs may be retrieved, but the patient decides not to go ahead with implantation ("dropped" cycle). Other times, there may be a medical reason to not retrieve or implant ("canceled" cycle), e.g., too few eggs to retrieve, failure of eggs to fertilize, failure of embryos to develop normally.

Individual	*Low*	*High*
Downstate	0.9%	1.0%
Upstate	0.9%	1.1%

IVF Mandates in Other States.[11] There are currently ten states that have IVF insurance coverage laws with varying degrees of coverage. In addition to dollar and/or cycle limits, some states require a lengthy history of infertility before receiving IVF coverage. Hawaii and Texas require a five-year history of infertility, while Maryland requires a two-year history. Some states also impose an age limit. New Jersey requires the patient to be less than 46 years of age, while Rhode Island only provides coverage for women between 25 and 42 years old. Massachusetts does not impose any of these limits but subjects the coverage to medical necessity. These differences make it difficult to assess particular fiscal impacts of different coverages, but provide some basis for assessing policy positions. Of note, all states with the exception of Delaware implemented IVF mandates prior to the implementation of the ACA. The following chart summarizes the existing state statutes.

Table 2: Other State IVF Coverage Mandates

	Limits				
State	Age	Dollar	Cycle	Other	Details
Arkansas		✓		✓	$15,000 lifetime maximum; requires two years of infertility
Connecticut			✓		Maximum of two cycles
Delaware	✓			✓	Egg retrieval must be before 45 years old; maximum of six egg retrievals
Hawaii			✓	✓	Maximum of one cycle; requires five years of infertility
Illinois				✓	Four egg retrievals are covered; if a live birth occurs, two more egg retrievals are covered
Maryland		✓		✓	$100,000 lifetime maximum; requires two years of infertility
Massachusetts					The law does not limit treatment cycles or have a dollar lifetime cap
New Jersey	✓			✓	Patient must be less than 46 years old; four egg retrievals are covered
Rhode Island	✓	✓			Patient must be between 25 and 42 years old; $100,000 maximum
Texas				✓	Requires five years of infertility

Cost-Savings and Other Benefits Associated with Mandating IVF Coverage

Wakely provided the following insights on potential costs and benefits of mandating IVF coverage. It is unclear whether such benefits would in the future translate into overall cost savings such that the premium estimates for mandating IVF coverage would be reduced.

Decisions Would be Based on Medical Advice. Patients will be motivated to make decisions based on doctors' medical advice rather than financial concerns. Without coverage, patients may take additional risks that coverage would reduce. In 2006, the American Society for Reproductive Medicine enacted guidelines encouraging single-embryo transfer for those with a favorable prognosis and transferring no more than two embryos in women younger than 35 years old and no more than three in those 35-37 years old. Insurance mandates would lower the incentive to "make the most" of each cycle, and in states with insurance mandates, fewer embryos are transferred each cycle. [12] Transferring fewer embryos reduces the risk of pregnancy complications and multiple births. Without cost significantly influencing

[11] Resolve, The National Infertility Association (site visited on January 24, 2019) *available at* https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/.

[12] When comparing certain state laws that mandate coverage, versus others that do not, the Center for Disease Control and Prevention (CDC) found that transferring three or more embryos was more common in the states without a mandate than in the states with a mandate.

their decisions, women considering IVF can focus on what is healthiest rather than what is most affordable, and doctors face less pressure from their patients to stray from the American Society for Reproductive Medicine's guidelines.

Lower Instances of Miscarriage. Coverage could require genetic screening that could reveal genetic issues that cause repeated miscarriages, which could lead to cost savings by adjusting treatment methods accordingly. For example, pre-implantation genetic diagnosis for aneuploidy testing (PGD-A) is a common method now used during IVF and has been shown to involve a higher sustained pregnancy rate per transfer and lower miscarriage rate.

Lower Lost Productivity Levels. Lost productivity due to time out of the office, short-term disability, or long-term disability can be managed more effectively through in-network doctors who follow guidelines that encourage safety. A 2006 Scandinavian study found that a group of employed women receiving a single embryo transfer had an average of nine fewer sick days taken off from work than women receiving a double embryo transfer (14.1 versus 23.0). The associated difference in cost of lost productivity between the two groups was on average approximately $850 less per person.

Decreased Instances of Depression in Infertile Couples. Offering fertility benefits can possibly offer a solution for infertile couples, and thus reduce any associated mental health costs. Studies have shown that the prevalence of major depression in infertile couples can range anywhere from 15% up to 54%, and the prevalence of clinically significant anxiety can range anywhere from 8% to 28%. This is due to couples experiencing multiple emotional hardships such as anger, depression, anxiety, marital problems, sexual dysfunction, and social isolation. The Journal of Clinical Psychology estimates that the economic burden of depression is approximately $210.5 billion per year, with about half of that cost being associated with loss of productivity in the workplace, and the other half being the true medical costs. When applying that to the population of couples struggling with both infertility and depression, Wakely estimates that the cost of depression due in part to infertility ranges from $3 billion to $10 billion a year in the U.S. However, going through infertility treatment, and failed attempts at IVF, can also have an adverse effect on mental health, which should also be considered.

Support for Women's and Same-Sex Equality in the Workforce

There is no question that there is increased demand for IVF services. This increased demand reflects a number of societal factors that New York supports and thus would support an IVF coverage mandate; at the same time, this increased demand would also result in higher utilization of the benefit and thus increased premium costs.

According to Wakely, demand for IVF should continue to grow due to the increased acceptance of assisted reproductive technology (ART) and same-sex partnerships. ART comprises all treatments that include the handling of eggs and sperm and/or embryos, such as artificial insemination and IVF. The number of ART cycles in the U.S. has increased 32% from 115,392 cycles in 2002 to 151,923 cycles in 2011, while infants born using ART increased by 34% from 45,751 to 61,610 in that same period. The Centers for Disease Control and Prevention (CDC) estimates that ART accounts for more than 1% of total U.S. births. Additionally, same-sex partners are becoming more widely accepted, both socially and legally, as candidates for fertility treatments. Women in same-sex relationships using donor sperm rose from 15% to 20% after same-sex marriage was legalized. It is estimated that up to six million children in the U.S. are parented by same-sex parents.

Two other factors, the rise in the age of first births and the increased rate of obesity, may also contribute to the demand for IVF services. The average age of first births among women is increasing, due to greater emphasis on careers, delays in marriage, and financial feasibility. The average age of first births in the U.S. has increased from 21 to 25 since 1970, driven primarily by an increase in first children born to women 35 and older. The percentage of first births in women aged 30 years or older increased from 5% to 26% from 1975 to 2010. Additionally, the rate of obesity is increasing and is having an adverse effect on the rate of fertility.[13]

Consideration for Pent-Up Demand

Wakely indicates that introducing IVF and other fertility benefits into a market where it was previously not widely offered may produce higher than average utilization in the first few years. About 9% of men and about 11% of women of reproductive age in the United States have experienced fertility problems and infertility affects approximately 10% of couples. Consumers may hold off on IVF or other fertility treatments due to the cost or the inaccessibility of non-covered benefits. If IVF benefits are covered under their health insurance, consumers would be more inclined to utilize the services, resulting in more immediate premium increases.

Wakely suggests this initial increase in utilization for IVF and other fertility benefits may dissipate in the years following initial successful implementation of the benefits. A fertility services group in Australia is seeing this with its first drop in IVF utilization following strong previous years. Once successful births have been achieved, the initial demand for fertility services may decrease. This is not an ongoing factor, however, as there will always be women who age into the benefit and will require fertility services each year. Nonetheless, were New York to mandate IVF coverage, the utilization for fertility benefits is likely to be high in the initial years and then should reduce to a steadier rate in the long run when compared to the initial demand.

Impact to Provider Networks

The addition of fertility benefits would require insurers to abide by the following network adequacy requirements applicable to specialists:

- At least two of each specialist provider type, potentially more based on enrollment and geographic accessibility, for each network;
- Preference that the specialists are within 30 minutes or 30 miles by public transportation or by car; and
- Providers must meet all requirements established by New York State, such as not being sanctioned or prohibited from participation in a federal health care program under either Section 1128 or Section 1128A of the Social Security Act.

Currently, providers have to comply with each insurer's credentialing standards to become an in-network provider. The imposition of standards and expansion of the provider network would have an associated cost for the insurers to contract with various additional providers, clinics, or facilities. However, many New York insurers are already offering some level of fertility benefits and would

[13] Obese women are three times more likely to suffer from infertility than women with normal body mass indices. Obese men also experience infertility issues since imbalances in hormone regulation can be tied to lower sperm production and various other factors, resulting in decreased sexual function and desire. Obesity rates for adults in the U.S. have more than doubled over the past 35 years with now 35% of the adult population considered obese in 2012. The obesity rate is expected to rise to 44% – or affect approximately 50 million lives – by 2030.

already have some in-network providers. The insurers may also have to update provider manuals and any additional providers would have to go through the insurer's credentialing process. While insurers would incur costs to develop a network of fertility providers, these costs would be considered when developing the premium rates associated with the benefit. As noted above, mandating the benefit would result in premium increases.

Other Possible Concerns

Although there are tremendous benefits to an IVF and FP mandate, there are additional potential downsides that would be created by a premium increase.

Loss of Coverage. Increased premiums typically lead some consumers to drop coverage.[14] Each year, insurance premiums increase due to the increased costs of health care, even without additional benefits provided. It is difficult to predict whether any increases from mandates in these areas would cause persons to drop coverage, and how many. However, given the potential premium increases referenced above, it is likely that some number of insureds who are barely able to afford their existing coverage will drop coverage as a result of a significant rate increase, all other things being equal.[15] Insofar as adding benefits will increase premiums by some amount higher than premiums otherwise would be, consideration should be given to whether to mandate the benefit, to reducing any mandated benefit from three mandated cycles, and/or to limit the mandate to large group policies.

Impact on Business. Another factor that merits consideration is the fact that businesses, and particularly small businesses, may raise concerns about this bill because it will result in higher premiums. According to one study, two-thirds of premium increases are paid for by wages and the remaining third from a reduction in benefits.[16] To preserve profits, firms faced with rising health care premiums may cut employment, reduce health benefits, raise prices, and reduce other expenses.[17] On the other hand, better benefits could help attract and retain a better educated and higher wage workforce. IVF and medically-necessary FP coverage are benefits that may be valuable to younger workers seeking to start or expand a family. Attracting and retaining a skilled workforce could help maintain and expand New York business.

Analysis of Fiscal Risk under the Affordable Care Act (ACA)

ACA Requirement to Defray Costs of State-Required Benefits. The ACA requires individual States (not private insurers) to defray the costs for any new State-required benefits that are in addition to essential health benefits (EHB) in the individual and small group markets (but not the large group

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[14] The Effects of Large Premium Increases on Individuals, Families, and Small Businesses, Matthew Buettgens, Bowen Garrett, and John Holahan, Urban Institute, *available at* https://www.urban.org/sites/default/files/publication/28576/412079-The-Effects-of-Large-Premium-Increases-on-Individuals-Families-and-Small-Businesses.PDF (2010).

[15] Minnesota's study found that for each additional $1 increase in average monthly premium, their state's individual market expected to lose 500 enrollees. Although the size of their individual market is smaller, like New York, they also have a Basic Health Plan. Actuarial Analysis and Certification for the Minnesota Section 1332 Waiver Application, Minnesota Department of Commerce Division of Insurance (May 30, 2017).

[16] The Labor Market and Effects of Rising Health Insurance Premiums, Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, Working Paper No. 11160 (2005).

[17] The Effect of Health Care Cost Growth on the U.S. Economy, Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services (September 1, 2007).

market).[18] The intent of this Federal requirement was reportedly to contain the proliferation of state mandates for which the Federal government would incur increased costs due to the enactment of the advanced premium tax credits. The ACA considers a benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, to be an addition to EHB.[19] A mandate, enacted through law, regulation or guidance, which requires coverage for a service, care or treatment is considered a new State-required benefit. The following State mandates are unrelated to specific care, treatment, or services and may be enacted without triggering a state fiscal: (1) provider types, (2) cost-sharing, (3) reimbursement methods, (4) delivery methods, (5) dependent-coverage, and (6) ACA conforming changes. The ACA further provides that the State is responsible for identifying which State-required benefits are in addition to EHB.[20] If a State-required benefit is in addition to EHB, the State must defray the cost by making payments directly to the enrollee or to the insurer on behalf of the enrollee. In such event, each qualified health plan insurer in the State shall quantify the cost attributable to each additional State-required benefit. The calculation must be based on an analysis performed in accordance with generally accepted actuarial principles and methodologies, conducted by a member of the American Academy of Actuaries, and reported to the State.

Potential State Cost for Medically-Necessary FP. As noted, current New York State law requires coverage for services to diagnose and treat infertility.[21] State law also provides that DFS shall promulgate regulations to include the determination of infertility in accordance with standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. New York statutory law does not mention FP, and the current definition of infertility does not include iatrogenic infertility. It is possible that an insurer or the federal government would argue that an expansion of the definition of infertility could be considered a benefit required by State action after January 1, 2012 and thus subject to a State fiscal. However, if the services covered under the infertility benefit itself are not being changed, the State has an argument that changing the definition of infertility to include iatrogenic infertility is not a new benefit, just a small expanded scope of the current infertility benefit to address a service for infertility treatment.

Potential State Cost for IVF. As noted above, current State statutory law requires coverage for services to diagnose and treat infertility but expressly excludes IVF from the mandate. At the time of the exclusion, during 2002, IVF was still a newer procedure and may have been considered experimental. Now, however, IVF has become more widely practiced over the past 15 years and is no longer considered experimental. The original intent of the 2002 State law was to treat infertility. Given that IVF is now an accepted procedure that has produced more than a million babies in the U.S.,[22] it should no longer be excluded from infertility coverage as being experimental. While an argument could be made that mandating this treatment for infertility would be amending an existing statutory mandate (i.e., not providing a new benefit), and the State should not incur a cost, the underlying risk remains.

As noted, the ACA's state fiscal requirement applies to the individual and small group markets, and not to the large group market. Wakely estimates that the potential added costs to the State for all insurers covering one cycle of IVF in the individual and small group markets would range from approximately $59 to $69 million per year. For three cycles of IVF in the individual and small group markets, the potential State cost would range from approximately $79 to $93 million per year. For unlimited IVF

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[18] 42 USC § 18031(d)(3).
[19] 45 CFR 155.170(a)(2).
[20] 45 CFR 155.170(a)(3).
[21] Unlike IVF, the State's infertility statute does not expressly exclude FP coverage.
[22] Penn Medicine, IVF Fast Facts, (site visited on October 9, 2018) *available at* https://www.pennmedicine.org/updates/blogs/fertility-blog/2018/march/ivf-by-the-numbers.

coverage, that potential State cost would range from $98 million to $116 million per year. Additionally, there could be increased costs to the State associated with the NYSHIP plan depending on coverage requirements. The charts below detail the projected 2020 State fiscal impact by area of New York using low and high estimated costs for IVF coverage with a one cycle limit, a three-cycle limit, and unlimited coverage.

Table 3-A: Projected 2020 Premium Increase Based on Increased Insurer Costs– One Cycle of IVF

Individual	*Low*	*High*
Downstate	$9,267,083	$10,905,735
Upstate	$4,405,442	$5,184,434
Subtotal	**$13,672,525**	**$16,090,169**
Small Group	*Low*	*High*
Downstate	$27,436,685	$32,288,174
Upstate	$17,944,430	$21,117,452
Subtotal	**$45,381,115**	**$53,405,626**
Large Group	*Low*	*High*
Downstate	$11,647,859	$13,707,490
Upstate	$1,547,375	$1,820,989
Subtotal	**$13,195,234**	**$15,528,479**
All Groups	*Low*	*High*
Downstate	$48,351,627	$56,901,399
Upstate	$23,897,246	$28,122,875
Total	**$72,248,873**	**$85,024,274**

Table 3-B: Projected 2020 Premium Increase Based on Increased Insurer Costs – Three Cycles of IVF

Individual	*Low*	*High*
Downstate	$12,356,111	$14,540,979
Upstate	$5,873,922	$6,912,578
Subtotal	**$18,230,033**	**$21,453,557**
Small Group	*Low*	*High*
Downstate	$36,582,246	$43,050,899
Upstate	$23,925,906	$28,156,603
Subtotal	**$60,508,152**	**$71,207,502**
Large Group	*Low*	*High*
Downstate	$15,530,478	$18,276,654
Upstate	$2,063,166	$2,427,986
Subtotal	**$17,593,644**	**$20,704,640**
All Groups	*Low*	*High*
Downstate	$64,468,836	$75,868,532
Upstate	$31,862,995	$37,497,166
Total	**$96,331,831**	**$113,365,698**

Table 3-C: Projected 2020 Premium Increase Based on Increased Insurer Costs – Unlimited IVF

Individual	*Low*	*High*
Downstate	$15,445,139	$18,176,224
Upstate	$7,342,403	$8,640,723
Subtotal	**$22,787,542**	**$26,816,947**
Small Group	*Low*	*High*
Downstate	$45,727,808	$53,813,623
Upstate	$29,907,383	$35,195,753
Subtotal	**$75,635,191**	**$89,009,376**
Large Group	*Low*	*High*
Downstate	$19,413,098	$22,845,817
Upstate	$2,578,958	$3,034,982
Subtotal	**$21,992,056**	**$25,880,799**
All Groups	*Low*	*High*
Downstate	$80,586,045	$94,835,665
Upstate	$39,828,744	$46,871,458
Total	**$120,414,789**	**$141,707,123**

Risks and Mitigation. A litigation risk exists if the State does not identify IVF as a new State-required benefit in addition to EHB. Insurers or other interested parties may pursue legal action against the State or request intervention from the Federal government. Accordingly, a statute mandating IVF or FP should explicitly provide that if the State determines these services do not constitute a benefit in addition to EHB, and the determination is overruled, the benefit would be automatically limited to large group comprehensive health insurance coverage to avoid the State fiscal. As a consequence, any mandate should have an effective date sufficiently in the future to assess actual litigation exposure.

Summary

A medically-necessary FP requirement with storage costs included would have a premium impact of approximately 0.02%. Per the analysis undertaken by DFS, changing the definition of infertility to include iatrogenic infertility is arguably not a new benefit, and therefore may not trigger a state fiscal.

Given the Affordable Care Act's requirement that states pay for new benefit mandates in individual and small group markets, mandating IVF coverage in those markets at this time poses a significant state financial plan risk. In addition, mandating IVF coverage in the individual and small group markets will have a premium impact that affects the State's concurrent efforts towards reducing both the uninsured rate and the amount of premium increases. Limiting an IVF mandated benefit to large group insurance policies mitigates that premium impact and avoids a State fiscal risk. Further, the State can continue seeking to identify a mechanism or path to limit the State financial plan risk of mandating IVF coverage for the individual and small group markets.